MOUNT SINAI UNION FREE SCHOOL DISTRICT

PO Box 397, North Country Road
Mount Sinai, New York 11766

Consent to Release Medical Information

Child: ____

D.O.B.____

I consent to the communication of medical information concerning

My child ______________________________________between:

____
(Name of Physician)

____
(Address)

____
(Phone & Fax #)

And

Wendy Kollmer, R.N.	RosAnne Hirdt, R.N.	Kathryn N. Pantino, R.N.
High School Nurse	Middle School Nurse	Elementary School Nurse
Fax: 928-3668	Fax: 473-6368	Fax: 928-3860
Phone: 870-2822	Phone: 870-2725	Phone: 870-2641

Parent Signature: ______________________________ Date: ____________________